

**AGENDA ITEM 4**  
**AUDIT RESOLUTION STATUS – HEALTH PLAN AUDITS**  
**(CURRENT YEAR REPORTS WITH CURRENT YEAR UPDATES)**  
**AS OF JUNE 30, 2008**

Name of Auditee (Report Issue Date)	Summary of Findings	Status/Comments
Review of Blue Cross of California (July 30, 2007)	<p>3.1 Blue Cross did not always acknowledge and resolve member appeals within the time frames specified in the Evidence of Coverage document. Only 78 percent were acknowledged within the required 20-day timeframe.</p> <p>5.1 Blue Cross' team of customer service staff are provided formal training; however, out of the transcripts reviewed, eight staff failed in one or more courses in 2006. Retesting is available but Blue Cross does not keep the records of the re-test. In addition not all staff took the required fraud and abuse class.</p> <p>5.2 Utilization management staff took the required fraud and abuse class but transcripts did not indicate proficiency. One staff member failed an on-line course and records did not indicate that the staff member completed the course successfully.</p> <p>8.1 Blue Cross has not achieved Utilization Review Accreditation Commission accreditation as required.</p> <p>10.1 Customer service reports are consistent with system generated reports except for two months, but the overall results show that Blue Cross still met the performance requirements. We recommend Blue Cross ensure data reported to CalPERS is consistent with underlying supporting documentation.</p> <p>11.1 We were unable to obtain the system generated reports in support of statistics reported for the response performance measure. The underlying data are only maintained for 180 days.</p>	<p>COMPLETE. Blue Cross updated its processes to ensure appeals are resolved within the time frame specified in the Plan's Evidence of Coverage booklets.</p> <p>COMPLETE. Blue Cross has updated its processes to maintain complete training records, document staff's proficiency for re-tests of failed courses, and ensure staff complete the required fraud and abuse course each year.</p> <p>COMPLETE. Blue Cross has updated its processes to maintain complete training records, document staff's proficiency for re-tests of failed courses, and ensure staff complete the required fraud and abuse course each year.</p> <p>IN PROGRESS. Desktop submission/application for the Utilization Review Accreditation Commission accreditation has been pushed back until January 2009. Accreditation process will ensue one to three months after desktop submission.</p> <p>COMPLETE. Blue Cross has a process in place to ensure all data reported to CalPERS will be consistent with underlying supporting documentation.</p> <p>COMPLETE. Blue Cross has a mechanism in place to maintain the data to support the statistics reported to CalPERS. The documentation will be stored by the Member Services Business Analyst and ready for future reviews.</p>

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Review of Blue Cross of California (July 30, 2007) <i>(continued)</i>	<p>12.1 The results for utilization management calls reported to CalPERS are consistent with generated reports except for three months.</p> <p>13.1 We were unable to obtain underlying documents for results reported on demand management telephone call answer times for nine of the 12 months reported in 2006 because these were managed by an outside vendor no longer used.</p> <p>15.1 We reviewed sample cases and information was consistent with underlying documents except for one case. Because this case did not meet requirements Blue Cross is subject to a penalty of approximately \$17,000.</p> <p>17.1 In one month, only nine physician reviewer appeals were audited by an MD peer instead of the required ten. This results in not meeting the Performance Guarantee which is a penalty of approximately \$13,000.</p> <p>20.1 Blue Cross changed its procedures prior to changing its contract regarding Medicare for eligible members' birthdays, but the contract still contains the former procedures.</p> <p>21.1 Blue Cross is required to credit CalPERS for all recoveries or overpayments subject to contract terms. Blue Cross is still working with CalPERS staff to discuss identification of recoveries and overpayments.</p>	<p>COMPLETE. Blue Cross has a process in place to ensure all data reported to CalPERS will be consistent with underlying supporting documentation.</p> <p>COMPLETE. Blue Cross has a mechanism in place to maintain the data to support the statistics reported to CalPERS. The documentation will be stored by the Member Services Business Analyst and ready for future reviews.</p> <p>COMPLETE. Blue Cross has calculated and reimbursed CalPERS the amount owed for not meeting performance guarantees for one month.</p> <p>COMPLETE. Blue Cross has reimbursed CalPERS the amount owed for not meeting performance guarantees.</p> <p>COMPLETE. The contract between CalPERS and Blue Cross has been amended to reflect Blue Cross' responsibilities for notifying Medicare eligible members.</p> <p>COMPLETE. Health Benefits Branch coordinated with Blue Cross to ensure reports provided identify recoveries and overpayments.</p>

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Review of California Correctional Peace Officers Association (CCPOA) Medical Plan (August 2, 2007)	<p>2.1 Eligibility reconciliation is performed quarterly, yet procedures state it should be done monthly. Our comparison of enrolled subscribers to CCPOA's union roster for December 2006 revealed 1,146 enrolled subscribers who were not full paying members as required.</p> <p>3.1 The Benefit Trust Fund could not provide the first quarter and annual reports for performance measures. Only three of four quarterly reports were obtained. We could not assess the reasonableness of certain performance measures reported only on an annual basis.</p> <p>5.1 Blue Shield of California submits to the Trust a fraud and abuse detection report each contract year. The report submitted on January 22, 2007 reported zero recoveries, yet the special investigations team showed recoveries in the 2nd and 3rd quarters of 2006.</p> <p>10.1 Blue Shield of California's disaster recovery plan was completed three months later than required. The plan included only 4 of the 5 required components. The plan and timeline for re-establishing communication after a disaster was not incorporated in the written plan.</p>	<p>COMPLETE. The CCPOA Benefit Trust Fund performs a reconciliation monthly after the 15th of each month. Letters are sent to those individuals that have an address on file with either CCPOA or CCPOA Benefit Trust Fund. Copies of the letters are provided to CalPERS at the time they are sent, as well as the Excel spreadsheet with the individuals who are enrolled in the Plan erroneously.</p> <p>COMPLETE. CCPOA Benefit Trust Fund acknowledges that it only received written documentation for the 3 quarters and the annual report for the period covered in the audit due to the Plan's newness. CCPOA Benefit Trust Fund has received a report for every quarter since the second quarter and expects to receive all future quarterly reports.</p> <p>COMPLETE. Blue Shield of California and CCPOA Benefit Trust Fund agreed to amend the reporting date to March 31 of each year for the previous January 1 through December 31. This modification will allow Blue Shield of California to prepare an accurate reporting of the fraud and abuse detection program. CCPOA Benefit Trust Fund will continue to monitor to ensure that the report is received in a timely manner.</p> <p>COMPLETE. CalPERS' audit team noted the deficiency in the disaster recovery plan and as a result Blue Shield of California corrected the plan and provided a copy to Office of Health Plan Administration and the Health Branch Business Continuity Coordinator.</p>

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Review of California Association of Highway Patrolmen Medical Plan (March 12, 2008)	<p>4.1 The underlying data for claims turnaround and accuracy and telephone responsiveness is maintained for only 11 months and was not available for review during our audit.</p> <p>5.1 In the first quarter, the telephone wait time exceeded the minimum performance standard. BCC compensated CAHP for failure to meet performance levels, but the compensation was late and the amount short. We recommend CAHP monitor the timely and accurate receipt of quarterly service performance compensation.</p>	<p>IN PROGRESS. Health Benefits Branch is scheduling a conference with the appropriate California Association of Highway Patrolmen and Blue Cross representatives to resolve this issue.</p> <p>IN PROGRESS. Health Benefits Branch is scheduling a conference with the appropriate California Association of Highway Patrolmen and Blue Cross representatives to resolve this issue.</p>
Review of Blue Cross Claims Review (Wolcott) (April 2, 2008)	<p>1.1 The individual out-of-pocket for two claims were in excess of the \$2,500 limit by \$6,360.40 and \$483.50 respectively. A similar issue was reported in Wolcott and Associates' previous audit dated May 2006.</p> <p>2.1 Wolcott identified two claims that were processed with in-network benefits and were non-emergent in nature.</p> <p>3.1 During the review of claims, Wolcott identified 2 out-of-network claims that indicated the patient had paid for the services in full and there was no signature assigning the benefits to the provider. Wolcott and Associates believe this incident of error is unacceptable.</p>	<p>COMPLETE. Further research found that the two error claims were not due to overriding accumulators or deductibles; but rather were due to other errors. Blue Cross has taken appropriate steps to resolve these issues.</p> <p>COMPLETE. Blue Cross has taken appropriate steps to resolve these issues. Refresher training using the claim exceptions has been provided to the CalPERS Claims examiners who input the claims data.</p> <p>COMPLETE. Blue Cross has taken the appropriate steps to resolve this issue. A training reminder was distributed to keyers for the correct determination of assignment of benefits.</p>

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Review of Blue Cross Claims Review (Wolcott) (4/2/08) (continued)	<p>4.1 Wolcott identified an out-of-network claim for mental health services. The claim indicated valid CPT codes and indicated the type of therapy that was provided (rolfing, art therapy, private yoga instruction, family and group family therapy, and substance abuse counseling). However, the CPT codes indicated did not match the type of therapy that was rendered to the patient. Family and group family counseling is specifically excluded in the plan booklet, which is typical. Rolfing, art therapy, private yoga instruction are types of therapy that are not covered by any plan sponsor with which we are familiar.</p> <p>5.1 Wolcott recommended Blue Cross enhance its procedures as they relate to investigation of End Stage Renal Disease and Medicare primacy. The current manual procedures would indicate that patients' information is not being followed up or investigated at all.</p> <p>6.1 Wolcott identified three claims for services performed by an acupuncturist. All three claims were out-of-network. The CalPERS benefit booklet indicates that out-of-network services provided by an acupuncturist should be reimbursed at a 60% benefit level. However, these claims were reimbursed at the in-network 80% benefit level. Blue Cross indicated to Wolcott that since there is an incomplete network of acupuncturists, they do not want to penalize the member.</p>	<p>IN PROGRESS. The case has been sent to the Risk Management Department for review and to initiate corrective adjustment (overpayment recovery).</p> <p>COMPLETE. Blue Cross has taken the appropriate steps to resolve this issue. An End Stage Renal Disease specialist has been added to log and track all new and potential cases. This was coordinated with CalPERS.</p> <p>IN PROGRESS. Blue Cross of California Account and Claims Management will schedule a meeting with CalPERS to discuss this issue.</p>

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Review of Blue Cross Claims Review (Wolcott) (4/2/08) (continued)	<p>7.1 Wolcott requested accident information for a patient receiving treatment for carpal tunnel, in order to establish that treatments were not work related. Blue Cross indicated that a letter had been sent to the member a week prior to the audit. When Wolcott inquired as to reason for the delay, Blue Cross indicated that Meridian (outsourced vendor) discovered that diagnosis codes with four digits were not being identified as requiring investigation. As a result, letters for these claims were generated in January 2008.</p> <p>8.1 Wolcott identified a large claim (in excess of \$100,000) where the initial processing of the claim applied the agreed upon per diem rates. However, the contract with this hospital indicates that if the claim exceeds \$65,000, then stop-loss pricing should apply. The contract also states that the hospital must send in this claim requesting stop-loss pricing rules be applied. Therefore, the hospital sent in a second submission requesting the stop-loss pricing and Blue Cross correctly adjusted the claim to reflect the stop-loss pricing and generated the additional payment. This is an inefficient process. In addition, in reprocessing of this claim, in order to adjust for the stop-loss provision, the additional \$857.70 that would have satisfied the member's out-of-pocket amount was not applied and was CalPERS' responsibility.</p>	<p>IN PROGRESS. According to Blue Cross, the lapse in discovery time will not affect future recoveries in this case because in California it has a two year statute of limitations to discover third party liability cases. However, Wolcott maintains that delay in gathering accident/potential third party liability may negatively affect the response rate.</p> <p>IN PROGRESS. Blue Cross maintains its procedures are correctly followed; however, CalPERS and Blue Cross should further discuss this issue, in order to come to an agreement on how to handle in the future.</p>

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Review of Blue Cross Claims Review (Wolcott) (4/2/08) <i>(continued)</i>	<p>9.1 Wolcott identified a claim with a diagnosis that is included in the DSM-IV list. This list is utilized by Blue Cross, as directed by CalPERS Evidence of Coverage, in order to identify mental/nervous disorders that should not have the mental health maximums applied.</p> <p>10.1 During Wolcott's review of a sample claim it noted that the mental health visits were in excess of plan limitations by one visit. The application of the extra visit was applied to a claim outside our sample of 350. Blue cross indicated to us that this was due to a coding error by the examiner.</p> <p>11.1 Wolcott identified a claim with a new patient exam code. This code cannot be billed by the provider unless it has been more than three years since it has seen the patient. Blue Cross indicated it would be a manual process to deny a claim for new patient that was less than three years since the last visit.</p>	<p>IN PROGRESS. Blue Cross maintains the claim in question was properly reimbursed as nervous and mental. Wolcott maintains that Blue Cross should be utilizing the DSM-IV list to establish mental/nervous disorders that should be paid as any other medical illness, and that CalPERS and Blue Cross should discuss this issue further.</p> <p>COMPLETE. Blue Cross has taken appropriate steps to resolve this issue. Further research found that the claim issue was the result of the examiner not using the proper type code to prompt the system. Refresher training has been provided to the CalPERS Claims examiners.</p> <p>IN PROGRESS. Until such time as the system can be enhanced, processors will have to review the history to ensure new patient exams are administered per the rules. Wolcott will review this issue again in future audit projects.</p>